The social and economic benefits of improving mental health

Women's Health Victoria's submission to the Productivity Commission Inquiry, April 2019

Introduction

Women's Health Victoria (WHV) welcomes the opportunity to provide input into the Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health. WHV is committed to improving women's mental health, including through advocacy and awareness raising, primary prevention, capacity building and direct service delivery. As a Victorian statewide women's health promotion service, we collaborate with health professionals, researchers, policy makers, service providers and community organisations to influence and inform health policy and service delivery for women.

WHV is committed to the social model of health which focuses on addressing the social and economic determinants of health, reducing social inequities and empowering individuals and communities.[1] We were encouraged by the Issues Paper's recognition of the need to examine how 'sectors beyond health, including education, employment, social services, housing and justice, can contribute to improving mental health and economic participation and productivity'. There is no doubt that these systems and sectors have an important role to play in supporting mental health and productivity across the community.

However, in addition to exploring how these social supports directly impact people with a mental illness (for example, how can people with mental health issues be supported to sustain housing), we recommend the Productivity Commission also investigate how the social determinants of mental ill-health (such as housing insecurity) can themselves be addressed to promote mental wellbeing, prevent mental ill-health, reduce costs and improve productivity. This means broadening the focus to include key determinants such as freedom from discrimination, harassment and violence on the basis of sex, gender, disability, race or sexuality, equitable access to economic power and resources, and reproductive autonomy. Comprehensive strategies at the population level to address these social determinants are likely to improve mental health in the population and reduce inequities, because such strategies focus on improving the conditions in which people are born, grow, live, work, and age.[2]

According to the World Health Organisation, **gender is a critical, overlaying social determinant of mental health and mental illness**:

> Gender determines the differential power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health

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[1] VicHealth (2018) Defining health promotion. Victorian Health Promotion Foundation. Melbourne. Available from: https://www.vichealth.vic.gov.au/media-and-resources/vce-resources/defining-health-promotion

[2] WHO (2014) Social determinants of mental health. World Health Organization. Geneva. Available from: https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf

risks. Gender differences occur particularly in the rates of common mental disorders - depression, anxiety and somatic complaints. [3]

However, the morbidity associated with mental illness has received substantially more attention than the gender-specific determinants and mechanisms that promote and protect mental health and foster resilience to stress and adversity.[4]

The Issues Paper largely fails to acknowledge sex and gender as key determinants of mental health, except for pointing out two instances in which men appear to fare less well than women (reduced pay as a result of mental illness, and suicide rates).

Recognising that gender is a key social determinant of health, WHV's submission aims to provide strong evidence that sex- and gender-based inequality drives unequal mental health outcomes between women and men in relation to a wide range of conditions and experiences, and that by addressing sex and gender we have the opportunity to significantly improve mental health outcomes and reduce the costs of mental ill-health.

Gender differences encompass biology, the roles and responsibilities that society assigns to men and women and their position in the family and community. Evidence confirms that these factors all have a great influence on the causes, consequences and management of diseases and ill-health and on the efficacy of health promotion policies and programmes.'[5] For example, factors associated with women's higher rates of depression and anxiety include poverty, discrimination, and socioeconomic disadvantage; insecure, low status employment; gendered expectations of high levels of unpaid domestic labour and caregiving; and differential exposure to physical and sexual violence in domestic settings.[6]

> 'There is an urgent need to counter the gender-blindness[7] of mental health policy which serves to make these experiences invisible. Policies which reinforce this invisibility are not only ineffective; they are part of the problem. It is time to change course.'[8]

Our submission therefore focuses on the need for an intersectional gender-sensitive approach to be applied to all areas of mental health policy, health promotion and service provision. This includes consideration of how both sex- and gender-based inequality (as well as other forms of discrimination such as racism and ableism) profoundly shape mental health outcomes, and consumers' experiences of the mental health system.

Structure of submission

This submission argues that there is a need to apply an intersectional gender lens to mental health reform – from prevention and early intervention through to treatment and recovery, including investing in (new and existing) intersectional gender equity strategies to support the primary prevention of mental ill-health.

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[3] WHO (2019) Gender and mental health. World Health Organization. Geneva. Available from: https://www.who.int/mental_health/prevention/genderwomen/en/

[4] WHO (2019) Gender and mental health. World Health Organization. Geneva. Available from: https://www.who.int/mental_health/prevention/genderwomen/en/

[5] Ostlin P, Eckermann E, Shankar Mishra U et al. (2006) Gender and health promotion: a multisectoral policy approach. *Health Promotion International* 21(S1):25-35. Available from: https://academic.oup.com/heapro/article/21/suppl_1/25/766144

[6] WHO. Department of Mental Health and Substance Dependence (2012). Gender disparities in mental health. World Health Organization. Geneva. Available from: https://www.who.int/mental_health/media/en/242.pdf

[7] While the term 'gender blind' is often used to describe approaches that fail to consider the role of sex or gender and therefore perpetuate gender inequality, in consultation with Women with Disabilities Victoria WHV now uses the term 'gender insensitive'.

[8] Duggan, Maria (2016) Investing in women's mental health: strengthening the foundations for women, families and the Australian economy. Australian Health Policy Collaboration, Melbourne. Available from: https://www.vu.edu.au/sites/default/files/AHPC/pdfs/investing-in-womens-mental-health.pdf

Preceding this, we have included a brief summary of some of the more urgent general issues in relation to the current provision of mental health services, including the importance of centring the voices of those with a lived experience of mental ill-health in mental health reform.

Our submission addresses the following themes:

1. Urgent issues with the current system

2. Centring the voices of those with lived experience

3. Evidence that discrepancies in mental health are strongly gendered

4. The social determinants of mental health for women and girls

5. Investing in gender equality is evidence-based and cost-effective

6. The need to invest in gender-sensitive approaches to improve the mental health of women and girls

7. Modelling the costs of mental ill-health

1. Urgent issues with the current system

While the majority of this submission is focused on WHV's specific area of expertise – addressing gender inequality as a driver of poor or unequal health outcomes – we would also direct the Productivity Commission to consider the following urgent opportunities to significantly improve the way that mental health services are delivered. This list of priorities was informed by the VCOSS consultation focused on this Inquiry held on the 13th of March 2019.

WHV supports calls to urgently reduce barriers to accessing mental health supports and services by:

1. **Funding mental health services to clear long waitlists in community and acute settings**. Mental health services should publicly list wait times and access to timely, appropriate support should be guaranteed. Every day that someone experiencing a mental health crisis does not have access to appropriate support puts that person at higher risk and/or has significant impacts on the productivity and wellbeing of those supporting them (such as family and friends).

2. **Prioritising access and continuity of care over service age limits**. Currently many services such as Headspace have firm age limits (12-25). Age limits should be made more flexible so that consumers at the outer limits of the target age cohort – for example, 11 year old and 26 year old consumers – are able to access continued support. Consumers should also be supported to transition between service types.

3. **Expanding the Medicare rebate for psychological treatment** beyond 10 sessions for those who need it.

4. **Supporting better integration between the acute system (particularly hospital emergency departments), community mental health services and 24 hour online and phone support for mental health**. There have been increasing numbers of Victorian patients left waiting for 24 hours (or more) in emergency departments for mental health care.[9] Victorian Agency for Health Information data shows that Victorian health services are not

9   Simon Judkins, President of the Australasian College for Emergency Medicine, quoted in: Perkins M (2019) Nothing between GP and emergency: Victoria's mental health failure. The Age (Mar 26). Available from: https://www.theage.com.au/politics/victoria/nothing-between-gp-and-emergency-victoria-s-mental-health-failure-20190227-p510ip.html

meeting targets for transferring mental health patients out of emergency departments.[10] Too many consumers and their families still report being turned away from emergency departments in the middle of the night and told to contact a community health service which is not open, has a long wait list, has limited capacity to take new patients and/or limited expertise in treating acute mental health conditions. Many consumers also report a lack of follow up after discharge from a hospital inpatient stay, which can result in readmission to hospital within a short period.

5. **Design, implement and evaluate mental health services in partnership** with those who have a lived experience, and their families/carers.

2. Centring the voices of those with lived experience

As the Commission is aware, Terms of Reference have recently been announced for the Victorian Royal Commission into Mental Health. More than 8000 submissions were received on the draft Terms of Reference. According to *The Age,* as of the 16th of January 2019, 75 per cent of submissions had come from women. More than 80% of those who made submissions have themselves used mental health services in Victoria in the last five years or someone close to them has.[11] Recognising this, the Royal Commission has made a commitment to approaching its work according to six guiding principles, including 'respecting the expertise of people living with mental illness' and 'inclusive engagement'.

It is likely that many of the submissions received by the Productivity Commission will also contain recommendations for improvements based on personal experiences. While we understand the Productivity Commission intends to focus on identifying the economic benefits of improving mental health, it is important that the experiences of those affected by mental illness now or in the past are also properly acknowledged and validated. Centring the experiences of people with lived experience of mental health problems from diverse backgrounds, including those who have used mental health services, will build confidence in the Productivity Commission's process and findings as well as helping to design effective solutions.

Given the particular needs and experiences of women, a support service with expertise in women's mental health should be resourced to support and coordinate consumer input from women, such as the [Victorian Women's Mental Health Network](12).

3. Evidence that discrepancies in mental health are strongly gendered

Globally, women are nearly twice as likely as men to suffer from mental illness.[13] In Australia, a survey of young people's mental health over a five year period found that females were around twice as likely as males to meet the criteria for having a probable serious mental illness. While the proportions of both males and females meeting the criteria for a probable serious mental illness have

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[10] Victorian Agency for Health Information (2019) Adult mental health ED presentations transferred to a mental health bed within 8 hours: quarterly data *In:* Victorian Health Service Performance. Statewide performance data: mental health. VAHI. Melbourne. Cited: 4 April 2019. Available from: https://performance.health.vic.gov.au/Home/Report.aspx?ReportKey=417

[11] Engage Victoria (2019) Royal Commission into Victoria's Mental Health System. Victoria. Department of Premier and Cabinet. Melbourne. Available from: https://engage.vic.gov.au/royal-commission-mental-health-terms-of-reference

[12] Victorian Women's Health Network [Website] Available at: https://wmhnv.org.au/

[13] Shoukai Y (2018) Uncovering the hidden aspects of inequality on mental health: a global study. *Translational Psychiatry* 9(98):1-10. Available from: https://www.nature.com/articles/s41398-018-0148-0.pdf

risen between 2012 and 2016, the increase has been much more marked among females (from 22.5% in 2012 to 28.6% in 2016, compared to a rise from 12.7% to 14.1% for males).[14]

Mental disorders represent the leading cause of disability and the highest burden of non-fatal illnesses for women in Australia.[15] Young women report the highest rates of mental disorder of any population group (30% for women aged 16 to 24).[16] There are also strong links between women's physical and mental health. Women are 1.6 times as likely as men to suffer coexisting mental and physical illness. These multi-morbidities are associated with increased severity of mental illness and increased disability.[17] Rigid gender-based expectations and stereotypes and gendered structural inequalities influence the stressors experienced by women and men, as well as the response they receive from health professionals and support services. But biological sex also plays a key role. Not only do women experience specific mental health conditions linked to their reproductive capacity such as post-natal anxiety and depression, the brain structure and response to stress also differ between females and males.[18]

> **Case study: Obsessive Compulsive Disorder**
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> Several gender differences in **Obsessive Compulsive Disorder** phenomenology have been identified: Women are more likely than men to report obsessions focusing on contamination (e.g. fear of spreading or contracting illness) and corresponding cleaning compulsions. Conversely, sexual obsessions (e.g. obsessive fears of being homosexual or being a paedophile) are more frequently observed in men. These gender differences appear to be stable across cultures, indicating that biological factors or cross-cultural gender norms play a role.[19] Women are more likely to experience co-morbid OCD and eating disorders, which may relate to gendered social roles. [20]

Other examples of the gendered experience of mental health include:

- **Exposure to male violence:** In Australia, two in every five women (41%) have experienced violence since the age of 15 years. Around one in three (34%) has experienced physical violence and almost one in five (19%) has experienced sexual violence. The negative impacts of violence on women's health include poor mental health, in particular anxiety and depression, as well as alcohol and illicit drug use and suicide.[21] An Australian study found that approximately 77% of women who have experienced three or four types of gender-based violence had anxiety disorders, 56% had

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14 Mission Australia, Black Dog Institute (2017) Youth mental health report: Youth Survey 2012-16. Mission Australia. Sydney. Available (direct download) from: https://www.missionaustralia.com.au/publications/research/young-people/706-five-year-mental-health-youth-report

15 Duggan, Maria (2016) Investing in women's mental health: strengthening the foundations for women, families and the Australian economy. Australian Health Policy Collaboration, Melbourne. Available from: https://www.vu.edu.au/sites/default/files/AHPC/pdfs/investing-in-womens-mental-health.pdf.

16 ibid.

17 ibid.

18 Shoukai Y (2018) Uncovering the hidden aspects of inequality on mental health: a global study. *Translational Psychiatry* 9(98):1-10. Available from: https://www.nature.com/articles/s41398-018-0148-0.pdf

19 Stein D, Vythilingum B (eds.) (2015) Anxiety disorders and gender. Springer International. Available from: https://www.springer.com/gp/book/9783319130590

20 Mathis, Alvarenga, Funaro, Torresan, Moraes, Torres, et al. (2011) Gender differences in obsessive-compulsive disorder : a literature review. *Revista Brasileira de Psiquiatria*. 33:390-9. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1516-44462011000400014

21 VicHealth (2017) Violence against women in Australia: research summary. Victorian Health Promotion Foundation. Melbourne. Available from: https://www.vichealth.vic.gov.au/media-and-resources/publications/violence-against-women-in-australia-research-summary

post-traumatic stress disorder and 35% had made suicide attempts.[22] A Victorian study found that 42% of women who died from suicide between 2009 and 2012 had a history of exposure to interpersonal violence, with 23% having been a victim of physical violence, 18% suffering psychological violence, and 16% experiencing sexual abuse.[23]

- **Depression and anxiety** rates among women and girls are high. A 2017 survey of over 10,000 Australian women found that 40% had been diagnosed with depression or anxiety.[24] The last National Survey of Mental Health and Wellbeing, held in 2007, found that women were significantly more likely than men to experience anxiety (32% compared to 20.4%) and depression (17.8% compared to 12.2%).[25] Twice as many adolescent girls from rural areas report symptoms consistent with depression compared to their male counterparts.[26]

- **Postnatal depression**: It is estimated that 20% of Australian women have experienced postnatal depression, that is, depression in the 12 months after birth.[27] WHV's issues paper, Great Expectations: How gendered expectations shape early mothering experiences[28], found that research is increasingly recognising that life stressors and social factors place women at increased risk of postnatal depression.[29] Fear of judgement and a desire to present as a 'good mother' leads to women concealing depressive symptoms and not seeking help.[30] There is also a strong association between poor social support and poor mental health in mothers.[31]

22   Rees S, Silove D, Chey T, Ivancic L, Steel Z, Creamer M, Teesson M, Bryant R, McFarlane AC, Mills KL, Slade T 2011, 'Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function'l, JAMA, vol. 306, no. 5, pp. 513–521

23   MacIsaac MB, Bugeja L, Weiland T, Dwyer J, Selvakumar K, Jelinek GA 2017, 'Prevalence and characteristics of interpersonal violence in people dying from suicide in Victoria, Australia', Asia Pacific Journal of Public Health, vol. 30, no. 1, pp. 3 6–44.

24   Women's Health Survey 2017 (2017) Jean Hailes for Women's Health, Melbourne. Available from : https://jeanhailes.org.au/survey2017/report_2017.pdf

25   ABS (2008) 4326.0 National Survey of Mental Health and Wellbeing: Summary of Results, 2007 Australian Bureau of Statistics. Canberra, p 27. Available from: https://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/$File/National%20Survey%20of%20Mental%20Health%20and%20Wellbeing%20Summary%20of%20Results.pdf

26   Webster A, Anderson R, Barr M (2017) Growing up unequal: how sex and gender impact young women's health and wellbeing. Women's Health Victoria. Melbourne. - (Women's Health Issues Paper; 12). Available from: https://whv.org.au/resources/whv-publications/growing-unequal-how-sex-and-gender-impact-young-womens-health-and

27   Perinatal depression: data from the 2010 Australian National Infant Feeding Survey (2012) Australian Institute of Health and Welfare, Canberra.

28   https://whv.org.au/resources/whv-publications/great-expectations-how-gendered-expectations-shape-early-mothering

29   Anderson R, Webster A, Barr M (2018) Great expectations: how gendered expectations shape early mothering experiences. Women's Health Victoria. Melbourne. - (Women's Health Issues Paper; 13). Available from: https://whv.org.au/resources/whv-publications/great-expectations-how-gendered-expectations-shape-early-mothering

30   Buchanan S, Loudon KJ (2015) "First-time mother syndrome"? first-time mothers' information practices and their relationships with healthcare professionals [Conference Paper] In: i3 Information Interactions and Impact Conference (2015 Apr. 23-26 : Aberdeen). University of Strathclyde, Glasgow. Available from: https://pureportal.strath.ac.uk/en/publications/first-time-mother-syndrome-first-time-mothers-information-practic

31   Holden L, Dobson A, Byles J, et al. (2013) Mental health: findings from the Australian Longitudinal Study on Women's Health. Women's Health Australia, Herston, Qld. - (Major Report H). Available from: https://www.alswh.org.au/images/content/pdf/major_reports/2013_major%20report%20H.pdf

Case study: Anxiety

Anxiety is a feeling of worry, nervousness or fear that is a normal response to stress.[32] However, when these anxious feelings are persistent, interfere with daily life and are out of proportion to the reality of a situation, an anxiety disorder may be present.[33] One in three women, compared to one in five men will experience an anxiety disorder in their lifetime,[34] and anxiety disorders are the leading contributor to the burden of disease in Australian girls and women aged five to 44.[35]

Types of anxiety disorders include generalised anxiety disorder (GAD), obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD), social phobia and panic disorder

Women's higher likelihood of developing anxiety symptoms and related disorders are thought to arise from a combination of genetic, biological and socio-environmental factors.[36]

Addressing social factors, such as exposure to poverty and violence, provides the greatest opportunity for anxiety prevention. For example, women who experience domestic violence are four times more likely to develop anxiety.[37] Low socioeconomic status is also associated with anxiety disorders.[38]

Case study: Suicide and self-harm

Suicide is often framed as a men's issue (reflecting higher overall prevalence among men). However, suicide research consistently demonstrates that women have higher rates of suicidal behaviour and, whereas the suicide rate for young men has decreased since the late 1990s, the rate for young women has increased[39]

Public attention and government and philanthropic investment in men's mental health has increased markedly over the last decade. The Commonwealth Government's 2011 *Taking Action to Tackle Suicide* package, for example, provided $23.2 million over four years for support services and campaigns to address male suicide in recognition of 'the social determinants that increase the risk of suicidality for men'.[40]

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[32] Office on Women's Health (2019) Anxiety disorders U.S. Department of Health and Human Services. Washington DC.

[33] Black Dog Institute (2018) What is anxiety? Black Dog Institute. Randwick, NSW

[34] ABS (2008) 4326.0 National Survey of Mental Health and Wellbeing: Summary of Results, 2007 Australian Bureau of Statistics. Canberra, p27

[35] AIHW (2018) Australia's health 2018: in brief Australian Institute of Health and Welfare, Canberra

[36] Remes O (2016) Women are far more anxious than men: here's the science. *The Conversation* (Jun 10).

[37] Trevillion K, Oram S, Feder G, et al. (2012) Experiences of domestic violence and mental disorders: a systematic review and meta-analysis. *PLOS One* 7(12): e51740.

[38] Mwinyi J, Pisanu C, Castelao E, et al. (2017) Anxiety disorders are associated with low socioeconomic status in women but not in men. *Women's Health Issues* 27(3), pp. 302-307.

[39] Suicide Prevention Australia (2016) Suicide and suicidal behaviour in women: issues and prevention, page 6. Available from: https://apo.org.au/node/56174

[40] GSANZ blog

Suicidal behaviour and self-harm in women can be viewed by family, health professionals and the community as attention-seeking, manipulative and non-serious,[41] which can negatively influence how young women are treated. Suicide prevention efforts have focused more on suicide mortality, which disproportionately affects men, rather than non-fatal suicide behaviours, which disproportionately affect women. Investment is now urgently warranted to investigate and address the social determinants of self-harm and suicidality in women.

Suicide is the leading cause of death for young women aged 15-24[42] and, alarmingly, the suicide rate among young women has increased by 47% over the past decade.[43] Further, nearly 1 in 3 girls aged 16-17 have self-harmed.[44] Measured by hospital admission, the intentional self-harm rate for women (which does not differentiate suicide attempts and non-suicidal self-injury) is now 40 per cent higher than men's, with a large increase in the adolescent years.[45] The number of women aged 15-24 years who injure themselves so severely that they require hospital treatment has increased by more than 50% between 2000 and 2016.[46]

Lesbian and bisexual women, people with intersex characteristics and trans women are at increased risk of suicidal behaviour, being almost four times as likely as their cis/heterosexual peers to have tried to self-harm or suicide.[471]

Aboriginal and Torres Strait Islander women are hospitalised for self-harm at twice the rate of non-Aboriginal women and hospitalisation rates generally increase with level of disadvantage and degree of remoteness.[48] Suicide rates among Aboriginal and Torres Strait Islander women aged 15-19 are nearly six times higher than the corresponding rates for non-Aboriginal young women.[49]

Case study: Addressing suicide and self-harm among Aboriginal and Torres Strait Islander communities

Connection to country and culture is important to the health of Aboriginal and Torres Strait Islander young women and strengthening this connection is widely

[41] Suicide Prevention Australia (2016) Suicide and suicidal behaviour in women: issues and prevention, page 8. Available from: https://apo.org.au/node/56174

[42] AIHW (2018) Deaths in Australia: web report. Supplementary tables. Table S3.2 leading causes of Death, by age group, 2014-16. https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia/data.

[43] ABS (2016) Intentional self-harm (Suicide) (Australia) : Table 11.3 - Intentional self-harm, age-specific death rates, 10 year age groups by sex, 2006–2015 [Excel download]. *In:* 3303.0 : Causes of Death, Australia 2015. Available from: https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3303.02015?OpenDocument

[44] Robinson J, McCutcheon I, Browne V, et al. (2016) Looking the other way: young people and self-harm. Orygen, The National Centre of Excellence in Youth Mental Health. Melbourne, p. 12. Available from: https://www.orygen.org.au/About/News-And-Events/Looking-the-Other-Way-Young-People-and-Self-Harm

[45] AIHW (2014) Suicide and hospitalised self-harm in Australia ; Trends and analysis, Flinders university, page 65 https://www.aihw.gov.au/getmedia/b70c6e73-40dd-41ce-9aa4-b72b2a3dd152/18303.pdf.aspx?inline=true

[46] Suicide Prevention Australia (2016) Suicide and Suicidal Behaviour in Women – Issues and Prevention, page 6. Available from: https://apo.org.au/node/56174

[47] Suicide Prevention Australia (2016) Suicide and Suicidal Behaviour in Women – Issues and Prevention, page 23. Available from: https://apo.org.au/node/56174

[48] Harrison JE, Henley G (2014) Suicide and hospitalised self-harm in Australia: trends and analysis: hospitalised intentional self-harm: 2010-11 Australian Institute of Health and Welfare, Canberra. Available from: https://www.aihw.gov.au/reports/injury/suicide-hospitalised-self-harm-in-australia/contents/table-of-contents

[49] Suicide Prevention Australia (2016) Suicide and Suicidal Behaviour in Women – Issues and Prevention, page 24. Available from: https://apo.org.au/node/56174

> considered the key to disrupting cycles of disadvantage.[50] Programs to address Aboriginal and Torres Strait Islander mental health and suicide prevention should include community-specific and community-led programs that focus on strengthening social and emotional wellbeing and cultural renewal, and should be delivered by community members.[51]
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> Recent research has found that Aboriginal young people have a high uptake of digital technology[1] indicating the potential for the development of effective specialist digital/online health resources for Aboriginal young people.
>
> The **iBobbly App** has been designed for Aboriginal young people aged 16-35 who are experiencing suicidal ideation and mental distress. iBobbly delivers messages and information to reduce suicidal thought in a culturally relevant way. Developed by the Black Dog Institute in partnership with Aboriginal organisations, the iBobbly pilot has received strong positive feedback. The app format overcomes geographical isolation and privacy concerns, giving it strong potential to reach those who don't normally seek help. [52]

WHV notes that the Productivity Commission intends to give greatest consideration to where there are the largest potential improvements in population mental health, participation and contribution over the long term. The Issues Paper states that this seems likely to include people with a mild or moderate mental illness (such as anxiety and depressive disorders), and young people, because most mental illnesses experienced in adult life have their onset in childhood or adolescence. WHV supports this focus, especially given disproportionate impact of anxiety and depressive disorders on women– including need to address social determinants and for gender-sensitive approach to early intervention and treatment.

WHV also supports the Productivity Commission's focus on young people. While girls and boys enjoy comparable levels of mental health and self-confidence before puberty,[53] during adolescence, young women's mental health outcomes worsen compared with young men's.[54] Evidence strongly indicates that this discrepancy is driven by sex- and gender-based expectations and experiences, and that the decline in young women's mental health is linked to societal factors rather than poor health care.[55]

For example:

- **Rates of depression, anxiety and psychological distress are on the rise in young women**. The Australian Longitudinal Study on Women's Health has found that about a third of

[50] Aboriginal Family Violence Prevention and Legal Service Victoria (2016) A Victorian Government gender equality strategy : submission by FVPLS Victoria, p. 15. Available from: https://djirra.org.au/wp-content/uploads/2018/02/Submission-A-Victorian-Gender-Equality-Strategy-FVPLS-Victoria-FINAL.pdf

[51] University of Western Australia. School of Indigenous Studies Solutions that work : what the evidence and our people tell us : Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report [ATSISPEP Report], p. 56. Available from: https://www.pmc.gov.au/resource-centre/indigenous-affairs/solutions-work-what-evidence-and-our-people-tell-us

[52] Black Dog Institute (2015) The extension of iBobbly : an app to reduce suicidality among young Aboriginal and Torres Strait Islander people : final report for the New South Wales Mental Health Commission, p. 2. Available from: https://nswmentalhealthcommission.com.au/sites/default/files/Final%20report%20iBobbly%20NSW.pdf

[53] Hankin B, Young J, Abela JRZ, et al. (2015) Depression from childhood into late adolescence : influence of gender, development, genetic susceptibility, and peer stress. *Journal of Abnormal Psychology.* 124 (4):803-16. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4662048/

[54] ibid. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4662048/

[55] Rowlands, Dobson and Mishra (2015) Physical health of young, Australian women : a comparison of two national cohorts surveyed 17 years apart. *PLOS One.* 10 (11 - e0142088):1-12. Available from: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0142088

young women have been diagnosed with or treated for either depression or anxiety.[56] A UK report found a 55% increase in rates of depression and anxiety among 11-13 year old girls between 2009 and 2014, but no such dramatic increase for boys.[57] This steep increase in depression and anxiety could be attributable to increased sexualisation and objectification of girls and young women, as well as exposure to social media and increased pressure on school performance.[58]

- Depression and anxiety are common in women with common **reproductive health conditions** like polycystic ovarian syndrome (PCOS). These conditions emerge during adolescence, though may not be diagnosed until much later. It has been shown that the longer it takes to receive a diagnosis of PCOS, the more likely women are to be depressed or anxious.[59] 70% of Australian women with PCOS remain undiagnosed, and there is a lack of consistency in assessment and management of the condition.[60]

- While **eating disorders** can occur across all ages, socio-economic groups and genders,[61] being female and experiencing puberty are key risk factors for the onset of an eating disorder.[62] Eating disorders are the third most common chronic illness in young females.[63] The mortality rate for people with eating disorders is the highest of all psychiatric illnesses, and over 12 times higher than for people without eating disorders. This includes increased risk of suicide.[64] Females aged 15–24 account for nearly three in five community mental health care service contacts for eating disorders (58%) and hospitalisations for eating disorders (57%).[65]

- Young women report considerably higher concerns about **body image** than young men (41.1% compared with 17%).[66] Poor body image limits women's participation in physical activity[67] and women and girls with poor body image are more likely to have unsafe sex.[68] More than half of Australian girls report that they are most often valued for their looks, rather

56 Mishra, Loxton, Anderson and et al. (2014) Health and wellbeing of women aged 18 to 23 in 2013 and 1996 : findings from the Australian Longitudinal Study on Women's Health, p. 110. Available from: https://www.alswh.org.au/images/content/pdf/major_reports/2014Major_Report%20I_FINAL.pdf

57 Ricci C (2015) Anxiety and depression in pre-teen girls rising. *Sydney Morning Herald* (May 4). Available from: https://www.smh.com.au/education/anxiety-and-depression-in-preteen-girls-rising-20150427-1mu842.html

58 Fink, Patalay, Sharpe and et al. (2015) Mental health difficulties in early adolescence : a comparison of two cross-sectional studies in England from 2009 to 2014. *Journal of Adolescent Health*. 56 (5):502-7, p. 505. Available from: https://www.jahonline.org/article/S1054-139X(15)00064-6/fulltext

59 Jean Hailes for Women's Health (2017) Health A-Z: endometriosis [Webpage]. Available from: https://jeanhailes.org.au/health-a-z/endometriosis

60 Boyle J, Teede HJ (2012) Polycystic ovary syndrome: an update *Australian Family Physician* 41(10): 752-756. Available from: https://www.racgp.org.au/afp/2012/october/polycystic-ovary-syndrome/

61 Eating Disorders Victoria (2015) Risk factors. EDV. Abbotsford, Vic. Available from: https://www.eatingdisorders.org.au/eating-disorders/what-is-an-eating-disorder/risk-factors

62 Treasure J, Claudino AM, Zucker N (2010) Eating disorders. *Lancet*. 375 (9714):583-93

63 NEDC (2012) An integrated response to complexity: National eating disorders framework. National Eating Disorders Collaboration. Sydney. Available from: https://www.nedc.com.au/research-and-resources/show/an-integrated-response-to-complexity-national-eating-disorders-framework

64 National Eating Disorders Collaboration (2012). Eating disorders in Australia. Sydney: NEDC. Sydney, p. 7. Available from: https://www.nedc.com.au/assets/Fact-Sheets/Eating-Disorders-in-Australia-ENG.pdf

65 AIHW (2018) Australia's health 2018: in brief Australian Institute of Health and Welfare, Canberra., p 16. Available from: https://www.aihw.gov.au/reports/australias-health/australias-health-2018-in-brief/contents/about

66 Mission Australia youth survey report 2016 (2016) Mission Australia, Sydney.

67 Physical Activity and Sport Participation Campaign : insights report (2016) TNS Consultants for the Australian Government Department of Health.

68 Weiderman (2012) Body image and sexual functioning *In:* Encyclopedia of body image and human appearance. Vol 1.

than their brains and ability.[69] Poor body image affects women of all ages but is most likely to begin in adolescence. Poor body image is associated with an increased probability of engaging in dangerous dietary practices and weight control methods.[70]

The **Victorian Women's Health Atlas**,[71] created by Women's Health Victoria, provides a 'one stop shop' for gendered health data in and across Victoria and includes mental health as a priority area. Mental health indicators include: anxiety and depression, personal wellbeing and psychological distress. We are currently in the process of adding gender-disaggregated data on self-harm based on Victorian hospital admission data.

4. The social determinants of mental health for women and girls

As acknowledged in the Issues Paper, sectors beyond health, including education, employment, social services, housing and justice, can contribute to improving mental health and economic participation and productivity.

However, in interrogating how these sectors interact with the mental health system, we need to first recognise that broader social determinants profoundly influence the ways that individuals, groups or communities, interact with these sectors.

The Productivity Commission must incorporate a closer examination of how social determinants such as **gender equity, freedom from violence and discrimination, and access to economic and social resources profoundly shape people's experiences, access to support and services and their mental health outcomes**.

For example, women are significantly more likely to experience sexual harassment in the workplace at least once, and sexual assault. A 2019 study has found that women with a history of workplace sexual harassment have significantly higher odds of hypertension and clinically poor sleep than women without this history. Women with a history of sexual assault have significantly higher odds of clinically significant depressive symptoms, anxiety, and poor sleep than women without this history.[72]

The onset of puberty can change the way young women feel about their bodies and abilities, as well as how they are treated by others, impacting their health and wellbeing. More boys than girls report that their parents let them walk or ride to places, or visit local parks on their own.[73] Young women report feeling concern about the presence of males when exercising and worry about being judged, humiliated and harassed.[74] This is pertinent to mental health because a growing body of evidence suggests that exercise is helpful in supporting good mental health.[75]

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[69] IPSOS Australia (2016) Everyday sexism : girls' and young women's views on gender inequality in Australia. Available from: https://www.ourwatch.org.au/getmedia/1ee3e574-ce66-4acb-b8ef-186640c9d018/Everyday-Sexism_version_03.pdf.aspx

[70] National Eating Disorders Collaboration (2010) Eating disorders prevention, treatment and management: an evidence review. NEDC. Sydney. Available from: https://www.nedc.com.au/assets/NEDC-Publications/NEDC-Evidence-Review-Final.pdf

[71] Women's Health Victoria (2019) Victorian women's health atlas. Women's Health Victoria. Melbourne. Available from: https://victorianwomenshealthatlas.net.au

[72] 2019 Available from: https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2705688

[73] VicHealth (2017) Youth (12-17) physical activity insights. Victorian Health Promotion Foundation. Melbourne. Available from: https://www.vichealth.vic.gov.au/media-and-resources/publications/life-stages

[74] van Bueren D, Elliott S, Farnam C (2016) 2016 Physical Activity and Sport Participation Campaign : insights report, p. 7. Available from: https://campaigns.health.gov.au/sites/g/files/net3246/f/insights_report.pdf

[75] Black Dog Institute (2017) One hour of exercise a week can prevent depression. Black Dog Institute. Randwick, NSW. Available from: https://www.blackdoginstitute.org.au/news/news-detail/2017/10/04/one-hour-of-exercise-a-week-can-prevent-depression

Case study: Housing, family violence and mental health

Family violence is the single biggest cause of homelessness in Victoria. More than one third of women accessing homelessness services do so because they're fleeing family violence.[76]

The relationship between family violence and homelessness is complex, as it is often underpinned by a range of factors such as gender inequality, socioeconomic disadvantage and mental illness, as well as poor access to income support and housing.[77] Women who have experienced domestic violence or abuse are at a significantly higher risk of experiencing a range of mental health conditions including post-traumatic stress disorder (PTSD), depression, anxiety, substance abuse, and thoughts of suicide.[78]

Compounding this, homelessness and inappropriate housing expose people to a wide range of risk factors for their mental and physical health and wellbeing. These include violence and abuse, harmful alcohol and other drug use, poor nutrition and sleep, severe social isolation, lack of amenities for self-care, disease, and even exposure to the elements. All of these are major stressors that are highly likely to compromise mental and physical wellbeing and pose additional challenges for providing continuing care.[79]

In contrast, safe, secure and stable accommodation is protective of health, including mental health.[80] Appropriate accommodation not only removes the risks associated with unsuitable accommodation or homelessness, but also provides a base from which a person with mental illness can focus on their recovery. It enables people to develop links with organisations and services within their community, and allows them to channel their energy into other factors supportive of their ongoing wellbeing (such as education or employment).[81] Affordable housing in safe neighbourhoods is essential for women experiencing family violence, single women and women with children.[82]

Sex and gender intersect with other forms of inequality to negatively affect mental health outcomes

Gender-based inequality and ableism intersect to influence the mental health of **women with disabilities.** This includes high levels of family and sexual violence and additional barriers to seeking support and leaving abusive relationships[83] including ableism. Women with disabilities are less likely to be in paid employment than their male counterparts, are more vulnerable to living in insecure or

76 Council to Homeless Persons (2014) Fact sheet: family violence and homelessness. CHP. Collingwood, Vic. Available from: https://chp.org.au/wp-content/uploads/2015/06/Family-violence-fact-sheet-FINAL.pdf

77 CHP Available from: https://chp.org.au/wp-content/uploads/2015/06/Family-violence-fact-sheet-FINAL.pdf

78 https://vincentcare.org.au/stories/latest-news/389-how-domestic-violence-affects-womens-mental-health How domestic violence affects women's mental health (2019)

79 Australia. Department of Health (2006) Accommodation *In:* Pathways of recovery: preventing further episodes of mental illness. Available from: http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-p-mono-toc~mental-pubs-p-mono-bas~mental-pubs-p-mono-bas-alt~mental-pubs-p-mono-bas-alt-acc

80 (Thomson, Pettigrew & Morrison 2001)

81 Australia. Department of Health (2006) Accommodation *In:* Pathways of recovery: preventing further episodes of mental illness. Available from: http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-p-mono-toc~mental-pubs-p-mono-bas~mental-pubs-p-mono-bas-alt~mental-pubs-p-mono-bas-alt-acc

82 (Blanch, Nicholson & Purcell 1998).

83 Voices Against Violence Paper One: Summary Report and Recommendations (2014) Woodlock, Healy and Geddes et. al, Melbourne.

inadequate housing and are more likely to live in poverty.[84] They are over-represented in institutional care and experience difficulties in accessing appropriate health services and treatment.[85] Forced sterilisation, contraception and menstrual suppression are also key issues facing women living with disabilities.[86] In 2012-18, 57% of people with a profound or severe disability reported experiencing a mental or behavioural health condition.[87]

Migrant and refugee women are less likely than Australian-born women to use preventative and primary health and social support services (and as such are overly represented in acute and crisis care) and less likely to have access to evidence-based and culturally relevant information to facilitate decision-making around their health.[88] Mental health (anxiety, depression and post-traumatic stress disorder)[89] and reproductive health are also areas of increased risk for these women.[90] Residency and visa status determines different health access entitlements, rendering the Australian health system difficult to navigate and can restrict access to health services for some visa-holders.[91]

The number of **incarcerated women** in Australia has increased by 50% in the past five years (compared with 37% for men),[92] and Aboriginal and Torres Strait Islander women are 21.2 times more likely to be incarcerated than non-Aboriginal women.[93] Beyond Blue reports that the most common mental health condition in incarcerated Aboriginal women is PTSD which is often misdiagnosed or not diagnosed.[94] Compared to male offenders, female offenders are 1.7 times more likely to have a mental illness,[95] more likely to have an acquired brain injury,[96] and more likely to have minimal employment histories, unstable housing and be the primary carer for children.[97] Prior to incarceration, these women have often experienced sexual assault and/or intimate partner violence.[98] 37% of

[84]   Assessing the situation of women with disabilities in Australia – a human rights approach (2011) Women with Disabilities Australia.

[85]   Women with Disabilities Australia (2009) Submission to the National Human Rights Consultation. WWDA. Tasmania. Available from: http://wwda.org.au/papers/subs/subs2006/

[86]   Sterilisation of Girls with Disability: The State Responsibility to Protect Human Rights (2018) Women with Disabilities Australia (WWDA): Hobart, Tasmania. Available from: http://wwda.org.au/wp-content/uploads/2018/09/Sterilisation-of-Girls-with-Disability-Cashelle-Dunn-2018-1.pdf

[87]   4364.0.55.001 - National Health Survey: First Results, 2017-18 , Australian Bureau of Statistics, 2019. Available from: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2017-18~Main%20Features~Mental%20and%20behavioural%20conditions~70

[88]   Sexual and Reproductive Health Data Report June 2016 (2016) Multicultural Centre for Women's Health, Collingwood. Available from: http://www.mcwh.com.au/downloads/MCWH_SRH_Data_Report_July_2016.pdf

[89]   Kirkmayer L, Narasiah L, Munoz M, et al. Common mental health problems in immigrants and refugees: General approach in primary care. CMAJ. 2011;183(12):E959-67

[90]   Keygnaert I, Guieu A, Ooms G, et al. Sexual and reproductive health of migrants: Does the EU care? Health Policy. 2014;114(2-3):215-25.

[91]   Women's Health Map: Assisting Immigrant and Refugee women to Navigate the Australian Health System, Peer Education Resource for Community Workers (2015) Multicultural Centre for Women's Health: Melbourne. Available from: http://www.mcwh.com.au/downloads/Womens_Health_Map.pdf

[92]   Corrective Services, Australia, September quarter 2018 (2018) Australian Bureau of Statistics. Available from: https://www.abs.gov.au/ausstats/abs@.nsf/mf/4512.0

[93]   Pathways to Justice–Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples (ALRC Report 133),(2017) Australian Law Reform Commission. Available from: https://www.alrc.gov.au/publications/indigenous-incarceration-report133

[94] [94]   The family business: improving the understanding and treatment of post-traumatic stress disorder among incarcerated Aboriginal and Torres Strait Islander women Beyondblue, 2015

[95]   Victorian Ombudsman Investigation into the rehabilitation and reintegration of prisoners in Victoria (2015) Office of the Victorian Ombudsman, Melbourne.

[96]   Acquired brain injury in the Victorian prison system Victoria. (2011) Corrections Victoria, Department of Justice, Melbourne.

[97]   Addressing women's victimisation histories in custodial settings (2012) Australian Institute of Family Studies, Melbourne. Prior to incarceration, these women have often experienced sexual assault, intimate partner violence.

[98]   The forgotten victims: prisoner experience of victimisation and engagement with the criminal justice system: key findings and future directions (2018) ANROWS, Melbourne.

incarcerated women are on medication for mental health issues (most commonly antidepressants or antipsychotics) compared to 25% of male prisoners.[99]

These significant inequities in mental health outcomes demonstrate the need for an intersectional gendered approach to mental health – from primary prevention, through to early intervention, treatment and recovery. Such work should both be informed by best practice (where available) and contribute to the evolving evidence base, and should include universal strategies as well as strategies tailored for different groups (for example non-English speakers).

5. Investing in gender equality is evidence-based and cost-effective

A number of factors come together to drive mental health outcomes for individuals including environmental factors, social determinants, genetic factors, and personal experiences such as exposure to trauma. Attention to social factors, especially inequality, is critical in approaches to mental health; these factors can be improved dramatically through the implementation of appropriate government policies and heightened community awareness.[100]

Greater equality between women and men is a precondition for (and an indicator of) equitable, prosperous and healthy communities and an important social determinant of health.[101] There are well established links between the risks of mental illness and the social realities of women's lives. These include women's relatively lower incomes and access to household resources and responsibility for childcare and other caring responsibilities, as well as experiences of sexual abuse and domestic violence.[102]

Empowered women contribute to the health and productivity of whole families and communities, and they improve prospects for the next generation.[103] When women and girls live free from violence, poverty, and rigid stereotypes that limit their potential, mental health is improved, the economy is stronger, and our pool of future leaders is more diverse.

By investing in and strengthening gender equity we can address the social determinants that lead to poor and unequal mental and physical health outcomes for young women. At the same time, investing in gender equity is also key to preventing violence against women, and can also improve the health and wellbeing of men and boys. An intersectional lens must also be applied to ensure interventions are sensitive and appropriate and that they support equity among girls and women.

Effective primary prevention and health promotion saves costs for government by reducing the need for acute and crisis support. As discussed in greater detail in section 4 above, gender inequality is recognised as the primary driver of violence against women. For this reason, primary prevention efforts in relation to violence against women have focused on gender equity.

99   The health of Australia's prisoners 2015 Australian Institute of Health and Welfare 2015

100   Shoukai Y (2018) Uncovering the hidden aspects of inequality on mental health: a global study. *Translational Psychiatry* 9(98):1-10. Available from: https://www.nature.com/articles/s41398-018-0148-0.pdf

101   According to the World Health Organisation, the social determinants of health are 'the conditions in which people are born, grow, work, live, and age' and the wider set of forces and systems shaping these conditions such as distribution of money, power and resources.

102   British Medical Association (2018) Addressing unmet needs in women's mental health. BMA. London. Available from: https://www.cancerresearchuk.org/sites/default/files/womens-health-full-report-aug2018_0.pdf

103   United Nations Population Fund (2015) Gender equality [Webpage]. Available from: https://www.unfpa.org/gender-equality

The approach taken to the primary prevention of family violence and all forms of violence against women in Victoria offers a useful example of the application of the public health approach to prevention. Its key features are:[104]

- A focus on addressing the 'drivers' of poor mental health (these might include gendered violence, trauma, housing and financial insecurity, and poor body image among others);

- An intersectional whole-of-population focus, supplemented by tailored approaches for specific population groups;

- Use of the socio-ecological model, which includes:

  - Addressing the structural, as well as individual, drivers of poor mental health

  - Mutually-reinforcing interventions across multiple settings where people live, work and play (such as schools, workplaces, sporting clubs etc)

In the case of violence against women in Victoria, this approach has been supported by a dedicated government strategy (*Free from Violence*) and accompanied by (limited) investment, with activity coordinated by a central body or bodies.

Any primary prevention strategy for mental health must address the gendered social determinants of poor mental health for women, men and gender diverse people, and link to existing frameworks and strategies that are already seeking to address these drivers, including the national framework for primary prevention of violence against women, *Change the Story*, the Victorian primary prevention strategy, *Free from Violence*, and the Victorian gender equality strategy, *Safe and Strong*. These frameworks and strategies identify effective approaches for addressing the gendered norms, practices and structures that drive gendered violence and poor health outcomes for women and men.

A strong focus on primary prevention does not detract from the importance of early intervention, treatment and recovery.

Case study: Growing Up Unequal

In 2017, WHV published *Growing Up Unequal: How sex and gender impact the health and wellbeing of young women*.[105] *Growing Up Unequal* examined young women's health and wellbeing between the ages of 10 and 20 from a multidimensional, holistic, intersectional perspective and found that:

Improving gender equality would lead to improved health outcomes and experiences for young women. Gender unequal norms, practices and structures continue to limit young women's equal and full participation in many aspects of life.

An intersectional approach is required to understand and respond to the experiences of young women. Some young women experience relative privilege while others experience relative disadvantage. Gender inequality is not the only system of oppression contributing to unfair or uneven health outcomes for young women.

Challenging sexualisation and objectification of women and girls at the societal level has the potential to improve young women's body image, increase their physical

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[104] Refer to Change the Story for an example of the application of this model in the PVAW space:
Our Watch, ANROWS and VicHealth (2015) Change the story : a shared framework for the primary prevention of violence against women and their children in Australia. Available from: https://www.ourwatch.org.au/getmedia/1462998c-c32b-4772-ad02-cbf359e0d8e6/Change-the-story-framework-prevent-violence-women-children.pdf.aspx

[105] https://whv.org.au/resources/whv-publications/growing-unequal-how-sex-and-gender-impact-young-womens-health-and

activity, and improve their mental and emotional wellbeing, sexual experiences and relationships.

Health professionals, parents and schools all have a role to play in challenging and changing the gender norms and expectations that limit and disadvantage young women.

6. The need to invest in gender-sensitive approaches to improve the mental health of women and girls

Failure to centre consideration of sex and gender in mental health can only contribute to inefficiency, ineffective interventions, and higher costs. A global study published in 2018 found a significant correlation between gender inequality and gender disparities in mental health and strongly suggested that 'women suffer mentally more than men in societies with greater levels of gender inequality.'[106] This alone justifies the need for a gender-sensitive approach to addressing the drivers of poor mental health outcomes, as well as the need for gender-sensitive services and supports.

> Gender-sensitive health service delivery is services/care that effectively addresses men's and women's different health care needs… Gender-sensitive services recognise and respond to a broader range of factors which impact on women's health, such as domestic violence, mental health, eating disorders, the effects of ageing and disability and women's multiple and often conflicting roles of workers, mothers and carers. [107]

Unfortunately, despite mounting evidence that sex and gender are critical in mental health, the needs and experiences of women have often not been considered in mental health policy or service design, or they have been considered of secondary importance.

Case study: Sexual safety in acute mental health inpatient units

In 2018 report from the Victorian Mental Health Complaints Commissioner found that 80 per cent of concerns about **sexual safety in acute mental health inpatient units** were about women's experiences. Women consistently reported feeling unsafe in a mixed-gender acute inpatient environment, with particular fears about being placed in intensive care areas (ICAs – also called high dependency units). The most common pattern of alleged 'sexual safety breaches' involved men breaching the sexual safety of women. Men were identified as individual perpetrators in 83% of complaints, and as having participated in a further 7% of 'sexual safety breaches'.[108] Despite consistent calls for **women-only inpatient wards** and growing international evidence that suggests this is critical for improving women's sexual safety in inpatient facilities, these are not routinely provided in Victoria.

The MHCC investigation included a comprehensive review of national and international literature. Among its chief recommendations is ensuring that unit planning, design and

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[106] Shoukai Y (2018) Uncovering the hidden aspects of inequality on mental health: a global study. *Translational Psychiatry* 9(98):1-10. Available from: https://www.nature.com/articles/s41398-018-0148-0.pdf
This is one of the first studies to successfully provide statistical evidence of an association between gender disparities in psychiatric disorders and social inequalities at a global level. The study results only demonstrated correlations rather than causal links between inequality and depressive disorders.

[107] Women's Centre for Health Matters (2009) WCHM Position Paper on Gender Sensitive Health Service Delivery. WCHM. Canberra. Available from: http://www.wchm.org.au/wp-content/uploads/2015/02/WCHM-position-paper-on-gender-sensitive-health-service-delivery.pdf

[108] The Right to be Safe: Summary Report (2018) Mental Health Complaints Commissioner, Melbourne. Available from: https://www.mhcc.vic.gov.au/news-and-events/news/ensuring-sexual-safety-in-acute-mental-health-inpatient-units

maintenance supports sexual safety, with a particular focus on responding to the needs of women and vulnerable consumers:

'Pilot and evaluate single-gender units, with a priority on piloting women-only units, and consider ways in which all inpatient units can be designed or adapted to provide additional flexible areas to meet the needs of varying inpatient populations, including trans or gender diverse people.'[109]

Applying a gender-sensitive approach to the provision of mental health services and supports

Prevention and early intervention initiatives (including education, peer support and specialist services) have the potential to significantly improve women's mental health, however they are often not sensitive to the specific risk factors, needs and experiences of women.

Mainstreaming a gender-sensitive approach to mental health policy and service provision – from primary prevention/ mental health promotion, through to early intervention, treatment (including both community and acute mental health services) and recovery – will help to address these inequalities. This approach would also include evidence-based gender-sensitive strategies for men and boys.

Unfortunately, despite widespread acceptance of gender as a key determinant of mental health, there is limited evidence about effective gender-sensitive interventions.

This highlights the need for significant investment in building the evidence base for gender-sensitive approaches. In relation to treatment and recovery, the International Association for Women's Mental Health notes that 'a number of approaches appear to promise a sound return on investment in women's mental health.'[110] These include trauma-informed care, single sex/gender services and peer support models.

Gender-sensitive approaches to mental health for women are evident in relation to post-natal depression and anxiety, but are notably lacking in relation to anxiety, anxiety disorders, depression and self-harm. Interestingly, gender-sensitive approaches seem to be more common and more generally accepted in relation to the mental health and wellbeing of men and boys. For example, the Sax Institute published an 'evidence check' in 2014 examining the evidence for a gender-based approach to mental health. The aim of the evidence check was to explore the evidence base for the proposition that 'being male' is a key consideration for understanding mental health outcomes and service development, that is, whether a gender-based approach to mental health programs is defensible, especially for prevention, early intervention and stigma reduction. The report found that:

> It is important that programmes take a gender-based approach to working with men because there is a strong relationship between adherence to traditional masculinity and poorer mental health help-seeking, higher levels of mental health stigma, suicide attempts and body image concerns.[111]

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[109] The Right to be Safe: Summary Report (2018) Mental Health Complaints Commissioner, Melbourne. Available from: https://www.mhcc.vic.gov.au/news-and-events/news/ensuring-sexual-safety-in-acute-mental-health-inpatient-units

[110] Duggan, Maria (2016) Investing in women's mental health: strengthening the foundations for women, families and the Australian economy. Australian Health Policy Collaboration, Melbourne. Available from: https://www.vu.edu.au/sites/default/files/AHPC/pdfs/investing-in-womens-mental-health.pdf

[111] Robertson S, Bagnall AM, Walker M (2014) Evidence for a gender-based approach to mental health programs. Sax Institute for the Movember Foundation. Available from: https://www.saxinstitute.org.au/wp-content/uploads/A-gender-based-approach-to-mental-health-programs.pdf

A range of prominent interventions are aimed at addressing the social determinants of men's health and/or providing gender-sensitive services for men. These include the national Men's Sheds Association, Men's Line and Movember.

Despite the lack of established examples of gender-sensitive mental health interventions or support for women and girls, there are many examples of guidelines or principles which are likely to lead to effective interventions, including the following example.

Gender sensitive mental health services for women and girls should:

- Prioritise understanding mental distress in the context of women's lives

- Be co-designed with women with lived experience

- Enable all dimensions of problems experienced to be addressed

- Address sexual abuse, domestic violence, body image concerns, reproductive and life stage elements of health and wellbeing

- Be sensitive to the diversity of women's needs, experiences and backgrounds including race, sexuality and disability

- Enable women to make choices about their care and treatment

- Provide women-only spaces, particularly in inpatient settings, which enable women to feel secure, safe and respected

- Empower women to develop skills for addressing their difficulties

- Promote self-advocacy and advocacy for women who need support to voice their views

- Value women's strengths and potential for recovery[112]

Furthermore, gender-sensitive service delivery understands that women who have fewer resources in terms of time, money, language proficiency and health insurance often face unique barriers to the healthcare system.[113]

The importance of an intersectional approach to improving women's mental health

Because gender inequality intersects with other social determinants such as racism, homophobia and ableism, as well as access to economic resources, some groups of women are more likely to experience poor mental health.

For example, twice as many rural adolescent girls report symptoms consistent with depression compared to their male counterparts.[114] While more research is needed to determine the effect of socio-economic status on rates of depression among rural populations, the study found that lack of availability and long waiting lists for mental health services, stressors involved in interpersonal relationships, and a perceived lack of mental health support accounted for higher rates of depression

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[112] British Medical Association (2018) Addressing unmet needs in women's mental health. BMA. London. Available from: https://www.cancerresearchuk.org/sites/default/files/womens-health-full-report-aug2018_0.pdf

[113] Women's Centre for Health Matters (2009) WCHM Position Paper on Gender Sensitive Health Service Delivery. WCHM. Canberra. Available from: http://www.wchm.org.au/wp-content/uploads/2015/02/WCHM-position-paper-on-gender-sensitive-health-service-delivery.pdf

[114] Black, Roberts and Li-Leng Depression in rural adolescents : relationships with gender and availability of mental health services. *Rural and Remote Health*. 12 (2092):1-11, p. 7. Available from: https://www.rrh.org.au/public/assets/article_documents/article_print_2092.pdf

among young rural women.[115] Gender-sensitive online interventions may help to improve outcomes for girls in rural areas.

Young women with disabilities are subjected to dual discrimination and stereotyping on the basis of gender and disability, adversely affecting self-esteem and expectations.[116] For young Aboriginal and Torres Strait Islander women, the compounding effects of a history of colonisation and dispossession, intergenerational trauma, removal from family and community, racism and discrimination[117] have a detrimental effect on mental health. Gender-sensitive supports for women with disabilities and Aboriginal women and girls should be designed and delivered by women from these groups.

Research suggests that same-sex attracted and gender queer (SSAGQ) young people living in rural and regional Victoria face added pressures due to higher levels of homophobia, increased surveillance, and reduced access to relevant information, resources and services.[118] Young people from migrant and refugee backgrounds are often reluctant to seek professional support with their psychosocial problems due to a range of individual, cultural, and service-related barriers.[119]

> **Case study: Addressing mental health in same sex attracted women from multicultural backgrounds**
>
> The **Our Voices, Changing Cultures Project**, delivered by the Multicultural Centre for Women's Health, was designed specifically to build resilience, capacity and leadership amongst young same-sex attracted women from culturally diverse immigrant and refugee backgrounds.
>
> Through the group discussions and performance-based workshops, the project created a space for young same-sex women to feel safe to discuss issues that affect them. Creating this space helped to link up same-sex attracted women who may be dealing with cultural and migration related issues with each other, enabling them to share their experiences and strategies, and helping to improve their mental health.[120]

Across the spectrum from prevention to recovery, investment should be guided by existing evidence, identifying examples of effective approaches and interventions, while at the same time identifying opportunities to test new and promising approaches and build the evidence base. Gender-disaggregated data should be collected and analysed to better understand the mental health needs, experiences and outcomes of women, men and gender diverse people.

7. Modelling the costs of mental ill-health

Establishing the financial costs of mental ill-health to individuals and the economy is complex. As with other social issues such as trauma or race-based discrimination, there will be significant costs to the

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[115] ibid., pp. 7,9. Available from: https://www.rrh.org.au/public/assets/article_documents/article_print_2092.pdf

[116] Women with Disabilities Australia (2015) Submission to the UN Committee on the Rights of the Child (CRC) : development of the General Comment on the Rights of Adolescents, p. 9. Available from: http://wwda.org.au/wwda-submission-to-the-united-nations-on-the-rights-of-adolescents/

[117] Suicide Prevention Australia (2016) Suicide and suicidal behaviour in women: issues and prevention, page 24. Available from: https://apo.org.au/node/56174

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[119] Centre for Multicultural Youth (2014) Mind Matters, p.8. Available from: https://www.cmy.net.au/sites/default/files/publication-documents/Mind%20Matters%202014.pdf

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economy in terms of lost productivity and delivery of health and social services, as well as profound impacts for those individually affected. It is difficult to assign a financial cost to these impacts not just because it is a complicated financial exercise, but also because doing so seems to undervalue the human rights/social justice imperative for addressing mental ill-health.

Violence against women is an example of an area of social policy related to mental health where the evidence in relation to costs to the economy has been established. We suggest that this approach should inform the Productivity Commission's approach to cost-modelling in relation to mental health.

Evidence has established that gender inequality is the underlying driver of violence against women,[121] and gendered violence is major contributor to women's mental ill-health, including chronic mental health conditions such as depression, sleeping and eating disorders, stress and anxiety disorders (such as post-traumatic stress disorder), poor self-esteem, self-harm and suicide attempts.[122]

In 2015, Our Watch and VicHealth commissioned PriceWaterhouseCoopers (PwC) to model the cost of violence against women. PwC estimated that the combined health, administration and social welfare costs of violence against women cost $21.7 billion a year, including $7.8 billion a year in direct costs to governments.[123]

The PwC report acknowledged that the health costs associated with violence include not only higher utilisation of health services to treat the effects of violence, but also longer term health costs such as depression and anxiety and substance abuse.[124] In addition to the serious physical health, mental health and social impacts on the individual, the PwC report took into account the fact that violence against women gives rise to enormous preventable downstream costs to the policing and justice systems, housing and homelessness services, health system and child protection services.[125]

The PwC report also demonstrates the potential economic benefits of investment in gender equality. It estimates that if a similar reduction in violence against women were achieved as has been the case for other community mobilisation and individual/direct participation programs, the benefits would range from $35.6 to $71.1 million over a lifetime for community mobilisation programs, and from $2.2 to $3.6 **billion** over a lifetime for individual and direct participation programs. These benefits far outweigh the initial program investment.[126]

This suggests that **investment in gender equality strategies will not only reduce the human and economic costs associated with violence against women, but also has the potential to reduce costs and improve outcomes in relation to women's mental health and wellbeing**. In this way, addressing gender inequality may be the most cost-efficient way to achieve improved outcomes and reduced costs in relation to a whole range of social and health issues. WHV recommends that the Productivity Commission gives this matter close consideration.

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[121] Our Watch, ANROWS and VicHealth (2015) Change the story : a shared framework for the primary prevention of violence against women and their children in Australia. Available from: https://www.ourwatch.org.au/getmedia/1462998c-c32b-4772-ad02-cbf359e0d8e6/Change-the-story-framework-prevent-violence-women-children.pdf.aspx

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[123] PricewaterhouseCoopers Australia (2015) A high price to pay : the economic case for preventing violence against women, p. 10. Available from: https://www.pwc.com.au/pdf/a-high-price-to-pay.pdf

[124] PricewaterhouseCoopers Australia (2015) A high price to pay : the economic case for preventing violence against women, p. 13. Available from: https://www.pwc.com.au/pdf/a-high-price-to-pay.pdf

[125] Our Watch, ANROWS and VicHealth (2015) Change the story : a shared framework for the primary prevention of violence against women and their children in Australia, p. 16. Available from: https://www.ourwatch.org.au/getmedia/1462998c-c32b-4772-ad02-cbf359e0d8e6/Change-the-story-framework-prevent-violence-women-children.pdf.aspx

[126] PricewaterhouseCoopers Australia (2015) A high price to pay : the economic case for preventing violence against women, p. 4. Available from: https://www.pwc.com.au/pdf/a-high-price-to-pay.pdf

Conclusion

Mental health and wellbeing is determined by a combination of genetic/biological, social/ environmental and personal/individual factors. These factors are strongly influenced by sex and gender. Despite this, major mental health policy frameworks, health promotion efforts and mental health service delivery have tended to take what is referred to as a 'gender-blind' or gender-insensitive approach, thereby missing key opportunities to design more (cost) effective interventions and improve outcomes. To the extent that gender-sensitive or gender-specific interventions have been designed and implemented, these have tended to be targeted at improving men's mental health, and have failed to recognise the significant impact of gender on the mental health of women and girls. In order to optimise health outcomes, a gender-sensitive approach should be applied to understanding and addressing all mental and physical health issues, and should include a specific focus on improving the mental health outcomes of women and girls. This is particularly critical in relation to conditions referred to in the Issues Paper including suicide and self-harm, eating disorders, and depression and anxiety.

In addition to gender, race, culture, class, employment status, sexuality, disability, age, and immigrant status are important determinants of women's health and equality. An intersectional approach is required to ensure that mental health interventions across the spectrum from prevention to recovery are inclusive of, and can reach, all groups of women.

There is irrefutable evidence that sex- and gender-based inequality drives unequal mental health outcomes. By investing in an intersectional approach to gender equality, we have the opportunity to significantly improve mental health outcomes and reduce the costs of mental ill-health, while simultaneously supporting the prevention of violence against women and improving equity, inclusion and wellbeing across the whole community.

Additional resources

WHV would like to take the opportunity to draw the Productivity Commission's attention to resources we consider particularly relevant to the Inquiry:

o   *Growing Up Unequal* (2017) - This paper by WHV explores how sex and gender impacts the health and wellbeing of young women and includes a focus on how gender inequality impacts mental health.

o   *Advertising (In)equality* (2018) - This paper by WHV provides an overview of significant literature currently published on the nature of gender portrayals in advertising, and the impacts of these representations on women's health and wellbeing. Gender-stereotyped portrayals limit the aspirations, expectations, interests and participation of women and men in our society. These portrayals are associated with a range of negative health and wellbeing outcomes.

o   *Great Expectations* (2018) – This paper by WHV explores how the perinatal period marks an enormous transition and upheaval in women's lives, challenging body image, relationships, intimacy and mental health. Research shows that when a woman's prenatal expectations regarding her pregnancy, delivery, infant, support network, and sense of self as a mother are compromised, she is more likely to experience lower levels of self-esteem and higher levels of depression, anxiety, and stress.

o   *I Never Realised They Were So Different: Understanding the impact of the Labia Library* (2018) - The Labia Library is an online resource developed by Women's Health Victoria (WHV) in response to increasing demand for female genital cosmetic surgery, also known as labiaplasty. The vast majority of survey respondents indicated a positive perception of the resource, often

experiencing a significant reduction in anxiety, and reassurance of normality associated with genital appearance.

o [Spotlight on Self-harm](#) (2018) - This WHV Spotlight features a list of up-to-date and freely available research and resources on the topic of women and self-harm. Self-harm rates are high for young women with a mental illness including depression, anxiety, post-traumatic stress disorder, and eating disorders. In Australia and internationally, self-harm in young women is on the rise, highlighting the need for widely available, gender-sensitive treatment which addresses coping behaviours as well as the reasons women turn to self-harm.

o [Spotlight on Anxiety](#) (2019) - This WHV Spotlight features a list of up-to-date and freely available research and resources on the topic of women and anxiety. One in three women, compared to one in five men will experience an anxiety disorder in their lifetime, and anxiety disorders are the leading contributor to the burden of disease in Australian girls and women aged five to 44. Women's higher likelihood of developing anxiety symptoms and related disorders are thought to arise from a combination of genetic, biological and socio-environmental factors.

o [Mental Health Indicators](#) displayed on the [The Victorian Women's Health Atlas](#) - The Victorian Women's Health Atlas was developed by WHV as a tool to assist in the identification of how gender impacts on key health areas including mental health. The Atlas enables comparison between Local Government Areas, Regions and the State. The purpose of the Atlas is to increase the availability of reliable data for evidence-based decisions about service design, emerging priorities and program planning. Indicators for mental health include personal wellbeing, close-knit communities, community connectedness, anxiety and depression and psychological distress.

o *[Investing in Women's Mental Health](#)* (2016) – This report from the Australian Health Policy Collaboration discusses the extensive evidence that women's mental health needs are significantly different from those of men. This paper argues that it is time for a new approach aimed at tackling gendered risks and enhancing protections across the life course.